Health & Wellness Intake Form ---------- REGISTERED MASSAGE THERAPY

ABOUT YOU

Full Name: _____ Birth Date (DD/MM/YYYY) ____ /____ /____ Age: _____

Address: _____ City: _____ Province: ____ Postal: _____

Phone #: (home) _____ (work) _____ (x)____

Emergency Contact: _____ Relation: _____ Phone #: _____

We use an automated email & text message system for appointment reminder reminders - please provide us with your contact info below and indicate (by checking the box & initialing) if you would like to receive these notifications. (You can receive emails, OR text, OR both email & text)

	appointment reminders & notifications	newsletter/promotional messages
E-mail Address: _____	____ (initial)	____ (initial)
Mobile Number: _____	____ (initial)	____ (initial)

How did you hear about Calm Massage Therapy & Wellness Studio? ☐ Friend – (who?)_____

☐ Internet ☐ Rack card/Business Card ☐ Mail-out ☐ Doctor ☐ Walk/Drive By ☐ Other _____

Regular Medical Doctor: _____ Care Card #_____

Do you have extended medical coverage? ☐ No ☐ Yes Do you have an active ICBC/WCB claim? ☐ No ☐ Yes

HEALTH HISTORY

Please indicate any conditions you have experienced. Indicate if it is a CURRENT condition (check first box) or a PAST condition (check second box):

C / P
- ☐☐ Arthritis
- ☐☐ Bursitis
- ☐☐ Compression Syndrome
- ☐☐ Contusion
- ☐☐ Degenerative Disc/Joint Disease
- ☐☐ Dislocation/ Subluxation
- ☐☐ Implants
- ☐☐ Ligament/ Joint Sprain
- ☐☐ Muscle Strain/ Spasm
- ☐☐ Postural Abnormality
- ☐☐ Rods/Pins/Plates/Shunts.
  Location:_____
- ☐☐ Spinal Injury/ Abnormality
- ☐☐ Tendonitis
- ☐☐ Tension Headache
- ☐☐ Transplants
- ☐☐ Other Musculoskeletal Condition
  Type_____

- ☐☐ Corrective Lenses/ Contacts
- ☐☐ Dizziness/ Fainting
- ☐☐ Epilepsy/ Other Seizures
- ☐☐ Head Injury
- ☐☐ Headaches/ Migraines
- ☐☐ Nausea
- ☐☐ Spinal Cord Injury
- ☐☐ Other Neurological Condition
  type: _____

C / P
- ☐☐ Contagious Skin Condition
- ☐☐ Eczema
- ☐☐ Serious Burn
- ☐☐ Pressure Ulcer
- ☐☐ Psoriasis
- ☐☐ Other Skin Condition
  Type_____

- ☐☐ Diabetes Type 1/2
- ☐☐ Hypo/ Hyperthyroidism
- ☐☐ Other Hormonal Condition:
  Type_____

- ☐☐ Circulatory Problem
- ☐☐ Heart Condition
- ☐☐ High/ Low Blood Pressure
- ☐☐ Varicose Veins
- ☐☐ Other Cardiovascular Condition:
  Type_____

- ☐☐ Constipation
- ☐☐ Diarrhea
- ☐☐ Irritable Bowel / Colitis
- ☐☐ Stomach Condition
- ☐☐ Ulcer
- ☐☐ Hernia
- ☐☐ Other Digestive Condition:
  Type_____

C / P
- ☐☐ Asthma
- ☐☐ Bronchitis
- ☐☐ Emphysema
- ☐☐ Sinusitis
- ☐☐ Other Respiratory Condition
  Type_____

- ☐☐ Allergic Reactions
- ☐☐ Autoimmune Disease
- ☐☐ Cancer
- ☐☐ Current Cold/Virus
- ☐☐ HIV
- ☐☐ Other Lymph/Immune Condition:
  Type_____

- ☐☐ Incontinence
- ☐☐ Kidney Disease
- ☐☐ Urinary Tract Infections
- ☐☐ Other Urinary Condition:
  Type_____

Other Health Conditions:

_____
_____
_____
_____
_____
_____

List any medical conditions that run in your family: _____

List any hospitalizations, major accidents / illnesses / surgeries you've had (include approximate DATES): _____

WOMEN: List the number of pregnancies/deliveries you've had (including dates) as well as any major complications associated with them:

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List any previous health & wellness care you have participated in:

	LAST VISIT DATE	REASON FOR CARE	TREATMENT ONGOING
Massage Therapy	_____	_____	yes / no
Chiropractic Care	_____	_____	yes / no
Physiotherapy	_____	_____	yes / no
Acupuncture	_____	_____	yes / no
Naturopathic Care	_____	_____	yes / no
Dietician/Nutritionist	_____	_____	yes / no
_____	_____	_____	yes / no

LIFESTYLE

List any medications, drugs, vitamins, minerals, or supplements you are taking and for what reason(s): _____
_____
_____
_____

List any known allergies (including medications, foods, seasonal, oils/lotions, etc.): _____
_____
_____

List any activities, exercise, sports, hobbies (jogging, soccer, crafts, computer, etc.): _____
_____
_____

Occupation: _____ How much do you work on average? _____ hrs/wk And vacation?_____

How do you spend most of your days at work? Sitting Standing Light Activity Moderate Activity Intense Activity Very Intense Activity
How do you spend most days outside of work? Sitting Standing Light Activity Moderate Activity Intense Activity Very Intense Activity

Please INDICATE how strongly you agree with these statements (1 = NOT AT ALL, 10 = ABSOLUTELY)

1 2 3 4 5 6 7 8 9 10	My average levels of stress & anxiety are low or non-existant	Stress
1 2 3 4 5 6 7 8 9 10	I'm able to control my emotional response to stressful situations (and don't react to triggers)	
1 2 3 4 5 6 7 8 9 10	My heart rate and blood pressure are excellent	
1 2 3 4 5 6 7 8 9 10	I never smoke cigarettes	
1 2 3 4 5 6 7 8 9 10	I breathe slowly & deeply into my belly for the majority of the day	
1 2 3 4 5 6 7 8 9 10	I meditate (or practice body/breath awareness) daily	
1 2 3 4 5 6 7 8 9 10	I have no problems falling asleep	Sleep
1 2 3 4 5 6 7 8 9 10	I sleep soundly for the full extent that my body requires each night	
1 2 3 4 5 6 7 8 9 10	I wake up refreshed & start each day with ease	
1 2 3 4 5 6 7 8 9 10	My energy levels are strong & consistent throughout each day	Energy
1 2 3 4 5 6 7 8 9 10	I consume caffeine very sparingly if at all	
1 2 3 4 5 6 7 8 9 10	I radiate positive energy each day and rarely dwell on the negative	
1 2 3 4 5 6 7 8 9 10	I eat nutritionally dense whole foods & avoid processed foods & additives (flavourings/colouring/sugars)	Nutrition
1 2 3 4 5 6 7 8 9 10	I take adequate & appropriate nutritional supplements to support my eating & lifestyle habits	
1 2 3 4 5 6 7 8 9 10	I have a healthy relationship with food	
1 2 3 4 5 6 7 8 9 10	I regularly drink adequate amounts of water (*at least* half my body weight in ounces per day)	
1 2 3 4 5 6 7 8 9 10	I drink alcohol very sparingly or not at all	
1 2 3 4 5 6 7 8 9 10	My digestive system is running smoothly and causing me no concerns	
1 2 3 4 5 6 7 8 9 10	I take excellent care of my skin (full body exfoliation, moisturization, short bursts of sun exposure)	Environmental
1 2 3 4 5 6 7 8 9 10	The body/skin/beauty products I use are free of chemicals, parabens, fragrances, & other toxic ingredients	
1 2 3 4 5 6 7 8 9 10	The household products I use are free of chemicals, fragrances, & other toxic ingredients	
1 2 3 4 5 6 7 8 9 10	I spend time outdoors, in nature, often	
1 2 3 4 5 6 7 8 9 10	I feel strong and able to do all physical activities to the extent that I'd like to	Fitness
1 2 3 4 5 6 7 8 9 10	My aerobic/cardio endurance is excellent	
1 2 3 4 5 6 7 8 9 10	My flexibility is excellent	
1 2 3 4 5 6 7 8 9 10	I'm able to recover quickly & efficiently from strenuous exercise	
1 2 3 4 5 6 7 8 9 10	I'm content with my current weight & BMI (Body Mass Index)	Body Physique
1 2 3 4 5 6 7 8 9 10	My body measurements are currently in my ideal range	
1 2 3 4 5 6 7 8 9 10	I'm content with the amount of muscle mass I have	
1 2 3 4 5 6 7 8 9 10	I currently have my most ideal body physique	

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MAIN HEALTH CONCERNS

PRIMARY COMPLAINT: _____ Pain level: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable)

Symptoms: _____

_____

_____

How long have you had this? _____

How did it begin? _____

What aggravates it? _____

What relieves it? _____

What are you unable to do because of this? _____

What other healthcare practitioners have you seen about this? _____

Type of care given? _____ Was it effective? _____

OTHER COMPLAINTS: _____ Pain level: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable)

Symptoms: _____

_____

_____

How long have you had this? _____

How did it begin? _____

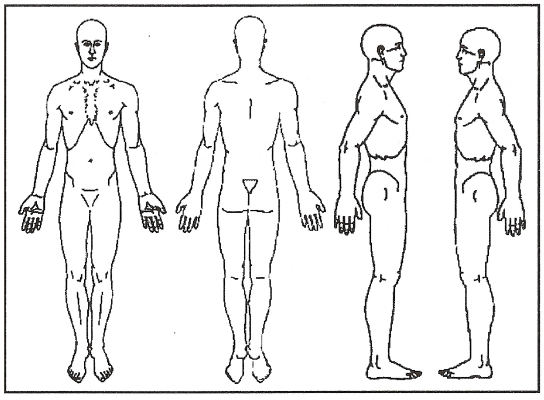
What aggravates it? _____

What relieves it? _____

What are you unable to do because of this? _____

What other healthcare practitioners have you seen about this? _____

Type of care given? _____ Was it effective? _____



SHOW ON THE DIAGRAM THE NATURE OF YOUR SYMPTOMS USING THE SYMBOLS INDICATED BELOW

ACHING ○	BURNING #	NUMBNESS ≈
TINGLING ∧	STABBING ×	SHOOTING →

How COMMITTED are you to improving your Health & Wellness??

1 2 3 4 5 6 7 8 9 10

What barriers are restricting you from achieving your FULL potential?

- ☐ Lack of focus or motivation
- ☐ Inability to create time in your schedule
- ☐ Inability to redirect finances to cover the cost of services/products
- ☐ Lack of knowledge or direction as to what to focus on or do
- ☐ Lack of support from my partner, family, or peers
- ☐ Pain/Restrictions/Limitations due to a particular health condition
- ☐ Too mentally overwhelmed
- ☐ Lack of energy to get started or push through
- ☐ Other _____

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FEE SCHEDULE

The fee schedule below applies to all persons paying privately. If you have extended medical coverage, please check your particular policy to see how much you will be reimbursed as plans vary between individuals - see section explaining direct billing below. If you are covered under ICBC or MSP Premium Assistance; please ask us for related forms & fee schedule.

Payment for all treatment whether private or insured is ultimately the responsibility of the patient.
GST applies to all fees listed below and these fees are subject to change without notice.

Since the COVID-19 pandemic, we require payment in advance of your booking in order to minimize administration time associated with each visit. Storing of a credit card in our encrypted server (Visa or Mastercard only) is mandatory to ensure payment will be successful -- this is required regardless of whether we submit to direct billing on your behalf or not. The total fee amount (or any payment amount remaining after direct billing has been processed) will be charged on the morning of your appointment. Any unsuccessful payments may be subject to a $10 administration fee (plus interest on any outstanding charges beyond 1 week of your visit.) We are unable to accept cash but will accept e-tranfers if requested, self vgtbhy

FEES FOR MASSAGE THERAPY TREATMENTS (Note: the higher rate is for our RMTs with over 10 years experience)

Twenty minutes *	$40 /$50
Thirty minutes *	$60 / $75
Forty-five minutes	$80 / $100
Sixty minutes	$100 / $125
Seventy-five minutes	$120 / $150
Ninety minutes	$140 / $175

ADD-ON TREATMENTS (not during COVID-19 restrictions)

Paraffin Therapy	$10
Stone Therapy	$20 / $25
HOME VISIT TRAVEL FEE (if within 15mins of our clinic)	$25

Youth (12 – 18 yrs) rates are $10 off the above. Children (up to 12 yrs) are 25 minutes for $35 / $45 and 40 minutes for $55 / $70 (also plus gst).

**20 and 30 minute length bookings are not accepted for first time visitors as we need more time for a thorough initial assessment.*

DIRECT BILLING

If you would like us to process direct billing to your extended medical insurance company please complete our *Assignment and Disclosure Form*. Note that we cannot bill insurance for missed or late cancelled appointments and will require private payment for those fees if incurred.

APPOINTMENT REMINDER & SCREENING CALL

In order to cooperate with requirements of our governing body, the College of Massage Therapist of BC, you will receive a phone call from your practitioner the day before your scheduled appointment. During this call you'll be asked screening questions in relation to COVID-19, be given any relevant instructions for your visit, and be asked to provide any updated billing information. If for some reason you are unable to accept this call or reply back to your practitioner in a reasonable amount of time, he/she will assume you are unable to make your booking and will offer the spot to another patient. PLEASE BE SURE TO PROMPTLY CALL/TEXT YOUR PRACTITIONER BACK SO THIS DOESN'T OCCUR IF YOU INTEND TO COME.

CANCELLATION / MISSED APPOINTMENT POLICY

Please understand that it is ultimately YOUR responsibility to be punctual for your visit. If you show up late, we will have to shorten your appointment time accordingly in order to be prompt and prepared for upcoming patients.

If you need to reschedule your appointment, please give us AT LEAST 24 HOURS NOTICE so that we can fill the space. Should an appointment be cancelled with less than 24 hours notice, 50% of your scheduled appointment fee will apply. Should an appointment be missed entirely without any notice, the full appointment fee will apply. **These fees will be charged to the credit card we have stored on your account**. This policy is in place because we do our best to respect you and your time and we expect the same from you in return. THANK YOU!

CONSENT FOR TREATMENT

Registered Massage Therapists (RMTs) are health care professionals committed to restoring and maintaining optimal health and pain-free function of the body. They are educated and trained to accurately assess and treat with techniques that include massage and manual therapy, joint mobilization, hydrotherapy, and rehabilitative exercise such as stretching, strengthening, postural exercise and patient education.

I hereby state that the above information that I have filled in is true and accurate to the best of my knowledge. I authorize Calm Massage Therapy & Wellness Studio and its associated RMTs to communicate with my Medical Doctor as deemed necessary for my treatment. I understand that a record will be kept of the health services provided to me at this clinic. This record, along with my personal information, will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I also understand that I am expected to notify my RMT if there are any changes to my health or medications/drugs I am taking OR if I am uncomfortable with ANY part of my massage therapy treatments. I understand that results are not guaranteed. I do not expect that the RMT will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the therapeutic procedures mentioned above.

I intend this consent form to cover the entire course of treatment with this Massage Therapist. **I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.** I understand that I will be receiving massage therapy as an adjunctive form of healthcare, and that I must continue to receive appropriate medical care from my Medical Doctor.

Patient Name: _____ Guardian Name (if patient is a child): _____

_____ _____
SIGNATURE OF PATIENT/GUARDIAN DATE